

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 932 00827

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Compton Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year 3 months  
 Hospital, institution, or street address where death occurred:  
Compton Maryland  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's  
 City or town Compton Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R. 2. # 2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

John Parren Bullock

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Mauda Bullock

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 4 - 1880

8. AGE: Years 67 Months 6 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Compton St. Mary's Maryland  
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name James H. Bullock

13. Birthplace St. Mary's Co

14. Maiden name Julia Thompson

15. Birthplace St. Mary's Co

16. Informant Mrs. Mauda Russell

Address 511 Maple Road S.E. Wash D.C.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 27, 1948  
 (month) (day) (year)

Cemetery or crematory St. Joseph Cemetery

Location Maryland

18. Funeral director W. E. M... ..

Address Leonardtown Maryland

19. 1/26/48 Registrar Cannalio

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 19 48, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10, 1947 to Jan 25, 1948

and that I last saw him alive on Jan 20, 1948

Immediate cause of death Cardio Vascular Disease DURATION

Due to Arteriosclerosis

Due to & Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. F. Greenwell M. D. or other

Address Leonardtown Md Date signed 1-26-48

RECEIVED  
JAN 28 1948  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00828

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 19

19. 48, at

?

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

none

19.

to none

19.

and that I last saw him alive on

19.

Immediate cause of death

Dead on arrival

DURATION

Patient was injured with  
Due to bad heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alonso &amp; Welch M.D.

M. D. or other

Address

Chopticon Md

Date signed 1/19/48

Francis Piccolo Burroughs

4. Sex

7

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug 17, 1884

8. AGE:

Years

Months

Days

If less than one day

63 1884

Aug

17

hrs. min.

9. Birthplace

St. Marys Co. Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none

12. Name

FATHER

Aquila Burroughs

13. Birthplace

Maryland

14. Maiden name

Mary Francis Fowler

15. Birthplace

Maryland

16. Informant

Carrie Burroughs

Address

Chopticon Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan 21 - 48

Cemetery or crematory

St. Joseph's Cemetery

Location

Maryland

18. Funeral director

Rose E. Welch

Address

Chopticon Md

19. 1/20

(Date rec'd by registrar)

19 48

Cavalier

Registrar

RECORDED

JAN 22 1918

FILED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00829

Reg. Dist. No. 284

## 1. PLACE OF DEATH:

County ST MARYSCity or town CHARLOTTE HALL  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles W. Butler

4. Sex

M

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug 8 1874

8. AGE:

Years

Months

Days

If less than one day

73621

hrs.

min.

9. Birthplace

ST MARYS CO MD  
(Town, county, and state)

10. Usual occupation

FARMING

11. Industry or business

FATHER

12. Name

John Butler

13. Birthplace

ST MARYS CO MD

MOTHER

14. Maiden name

?

15. Birthplace

16. Informant

William Butler

Address

Mechanicsville MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2-2-48  
(month) (day) (year)

Cemetery or crematory

ST JOSEPHS

Location

MARYANZA MD

18. Funeral director

ELMER M. QUADE

Address

Hughesville MD

19. Date rec'd by registrar

Jan 31 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

ST MARYS

City or town

CHARLOTTE HALL  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-48 19 48 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 12 1948 to January 29 1948  
and that I last saw him alive on January 28 1948Immediate cause of death Cardiac Failure

DURATION

30 days

Due to

Coronary SclerosisUndeter-  
mined

Due to

Generalized Arterio-  
sclerosisUndeter-  
mined

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John N. Griffin, M.D.  
M. D. or other

Address

Hughesville MD

Date signed

1/31/48

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FEB 3 1948

BUREAU



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary's  
 City or town Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Henry Camalis

## 3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Olus Camalis  
 7. Birth date of deceased (mo., day, yr.) Jan. 31, 1897 8. (c) If alive, give age 49 years  
 8. AGE: Years 50 Months 11 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ind (Town, county, and state)  
 10. Usual occupation Lawyer  
 11. Industry or business \_\_\_\_\_  
 12. Name Olus Camalis  
 13. Birthplace Ind  
 14. Maiden name Olus Rebecca Hrydu  
 15. Birthplace Ind

16. Informant Paul D. Camalis  
 Address Lanham MD  
 17. Burial Date thereof 1/19/48  
 (Burial, cremation, or removal) Which? (month) (day) (year)  
 Cemetery or crematorium St. Charles  
 Location Lanham Ind  
 18. Funeral director W.B. Marzough Inc  
 Address Lanham Ind  
 19. 1/17 48 Camalis  
 (Date) (rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 48 at 4:15 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1948 to 19  
 and that I last saw him alive on Dec 16 48

Immediate cause of death Myocardial  
Infarction

## DURATION

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul D. Camalis M. D. or other \_\_\_\_\_  
 Address Lanham Date signed 1/17/48

MASSACHUSETTS DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER

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JAN 20 1948  
ST. PAUL



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 286

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Burial  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County St. Mary's  
City or town Burial  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

James Henry Carter

### 3. (b) Social Security Number

4. Sex m 5. Color or race col 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Burial at Carter

7. Birth date of deceased (mo., day, yr.) 8-12-1882 8. (c) If alive, give age..... years

8. AGE: Years 65 Months 5 Days 0 If less than one day..... hrs. .... min.

9. Birthplace Burial St. Mary's  
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name Francis Carter

13. Birthplace Wilmington

14. Maiden name Augusta Wilson

15. Birthplace Wilmington

16. Informant John Francis Carter

Address Wilmington

17. Burial Date thereof 1-16-48  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Burial

18. Funeral director M.C. Washington

Address Wilmington

19. 1-14-48 R.V. Palmer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-48 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-26-48 to 1-12-48

and that I last saw him alive on 1-7-48

Immediate cause of death Coronary thrombosis DURATION

Due to Coronary thrombosis

Due to Coronary thrombosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert V. Palmer

M. D. or other

Address Wilmington Date signed 1-14-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 284

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Near Mechanicsville, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
City or town near Mechanicsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

JAMES WILLIAM COUNTESS

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

### 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 14 1875 6.(c) If alive, give age.....years

8. AGE: Years 72 Months 11 Days 26 If less than one day  
.....hrs. ....min.

9. Birthplace St. Marys Co. Md  
(Town, county, and state)

10. Usual occupation Farmer

### 11. Industry or business

12. Name Joseph Countess

13. Birthplace St. Marys Co. Md

14. Maiden name Julia Countess

15. Birthplace St. Marys Co. Md

16. Informant Walter Countess

Address Mechanicsville Md

17. Burial Date thereof 1-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph

Location Morganza, Md

18. Funeral director Elmer M. Quade

Address Hughesville, Md

19. Jan. 10 1948 Eleanor S. Carter  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1948 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5<sup>th</sup> 1948 to Jan 10<sup>th</sup> 1948 and that I last saw him alive on Jan 9<sup>th</sup> 1948

Immediate cause of death

DURATION

Cardiac Failure

Due to Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Levin J. S. Thomas M. D. or other

Address 6000 H. Hall Date signed 1/10/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 12 1948

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. MarysCity or town Rural (Leonardtown)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County St. MarysCity or town Leonardtown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural  
(If rural, give LOCATION)2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Anthony Desales Delojier

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Nellie Delojier7. Birth date of deceased (mo., day, yr.) Dec. 5, 1891 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Tr. driver

11. Industry or business

12. Name John B. Delojier13. Birthplace Maryland14. Maiden name Karriett C. Thompson15. Birthplace Maryland16. Informant Wm W. DelojierAddress Leonardtown17. Burial Date thereof 1/15/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. MichaelsLocation Ridge Ind.18. Funeral director P.B. RobinsonAddress Leonardtown, Md.19. 11/13 19 48 Carnalier  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 19 48 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 47, to Jan 12 19 48  
and that I last saw him alive on Jan 11 19 48

Immediate cause of death

Carcinoma of  
Stomach & liver

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul A. Carnalier  
M. D. or other  
Address Leonardtown Date signed 1/13/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 284

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Rural Mechanicsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Marys  
 City or town Rural Mechanicsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Gerald E. Dyson

## 3. (b) Social Security Number

\_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Adelle Dyson  
 7. Birth date of deceased (mo., day, yr.) June 27, 1897 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 50 Months 7 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Teacher  
 11. Industry or business \_\_\_\_\_  
 12. Name Joseph Dyson  
 13. Birthplace Maryland  
 14. Maiden name Jennie Graves  
 15. Birthplace Maryland

16. Informant Mrs. Adelle Dyson  
 Address Mechanicsville Md  
 17. Burial Burial Date thereof 2-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph  
 Location Maryland  
 18. Funeral director Blair M. Quade  
 Address Highsville, Md.  
 19. Jan. 31, 1948 Eleonora S. Carter  
 Date rec'd by registrar Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 19 48 at 7:15 A.M.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 17 19 47 to Jan. 31 19 48  
 and that I last saw him alive on Jan. 20 19 48  
 Immediate cause of death Carcinoma of Stomach  
 DURATION 2 yrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Metastases to lymph nodes and liver  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Carcinoma of Stomach with metastases Date of op. June 17, 1947  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE William J. Davis M.D.  
 Address Leonardtown, Md. Date signed 1/31/48

RECORDED

FEB 3 1948

SUBS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Jarboesville md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Mary's  
 City or town Jarboesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

William Lester Elridge

## 3. (b) Social Security Number

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1947 8.(c) If alive, give age 16 1/2 years

8. AGE: Years 0 Months 4 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Jarboesville St. Mary's Maryland  
 (Town, county, and state)

10. Usual occupation Baby

11. Industry or business

12. Name Clay Elridge13. Birthplace St. Mary's co14. Maiden name Edith Youn15. Birthplace St. Mary's co16. Informant Clay ElridgeAddress Jarboesville Maryland17. Burial Date thereof Jan 15, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter ChurchLocation Ridge Maryland18. Funeral director W. C. Mattingly SonsAddress Leonardtown Md.19. Jan 15 19 48 Cummins

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 19 48 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

see only post mortem 19

and that I last saw h..... alive on 19

Immediate cause of death acute toxico. bronch.Due to infant

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

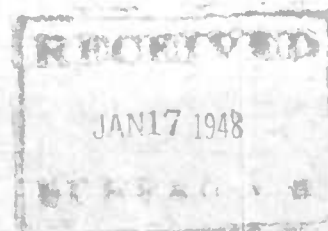
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Mattingly med. dir.Address Leonardtown Md. M. D. or otherDate signed 1/15/48

(over)

Birthe cent. on file as Wm. Gordon Jackson



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary'sCity or town NAS Patuxent River  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 Mo.

Hospital, institution, or street address where death occurred:

MOO 907 B NAS Patuxent River

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town NAS Patuxent River  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 NAS Operations Department  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Elizabeth Jo Ettinger

## 3.(b) Social Security Number

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
--------------------	------------------------------	--

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 22 September 1947

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>3</u>	<u>18</u>	..... hrs. .... min.

9. Birthplace NAS Patuxent River, St. Mary's, Md.  
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Raymond Lester Ettinger13. Birthplace Mill City, Oregon14. Maiden name Mary Frances Durand15. Birthplace Redmond, Oregon16. Informant LCDR Raymond L. Ettinger USNAddress NAS Patuxent River, Md.17. Burial Date thereof 1/13/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Virginia19. Funeral director JP B. RobinsonAddress Leonardtown, Md.19. 1/13 1948 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 1948 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
9 January 1948 to 9 January 1948and that I last saw her alive on Not seen 1948Immediate cause of death Asphyxia

DURATION

Due to Aspiration of vomited food.  
Found dead in crib.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results Food in trachea, mottling of lungs,  
PHYSICIAN: Please underline the cause to which dilation of aortic

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.S. WRAY CDR MC USN M. D. or otherAddress NAS Patuxent River Md Date signed 9 Jan 1948





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Hollywood, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's  
 City or town Hollywood, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Rolland Fenwick

## 3. (b) Social Security Number

✓

4. Sex m5. Color or race colored6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Bertha Fenwick7. Birth date of deceased (mo., day, yr.) August 24, 1907

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 40 Months 4 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation laborer

11. Industry or business \_\_\_\_\_

12. Name William Fenwick13. Birthplace Maryland14. Maiden name Bessie Stevens15. Birthplace Maryland16. Informant Etta JacksonAddress 1329 - R ST. N.W. Wash. D.C.17. Burial Date thereof 1/22/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Hollywood18. Funeral director P. B. RobinsonAddress Leonardtown, Md.19. 1/22 48 Caecilia  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1948 at 8:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21st 1947 to Jan 17, 1948 and that I last saw him alive on Jan 11, 1948Immediate cause of death Inter Cerebral Hemorrhage DURATION 8 daysDue to arteriosclerosis 400 yrs.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. J. Fenwick M. D. or otherAddress Leonardtown Md. Date signed 1-20-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 24 1948  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00838

Reg. Dist. No. 286

### 1. PLACE OF DEATH:

County St. Marys  
 City or town Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County St. Marys  
 City or town Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3. (a) FULL NAME

Carroll Fay Beares

### 3. (b) Social Security Number

4. Sex ♂ 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1-18-48 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
1 1 1 1 min.

9. Birthplace Brunswick  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Robert Paul Beares

13. Birthplace Brunswick

14. Maiden name Agnes Beaudouin

15. Birthplace Brunswick

19. Informant Robert P. Beares

Address Brunswick

17. Burial Date thereof 1 19 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Brunswick

Location Brunswick

18. Funeral director W. Elvin Beares

Address Brunswick

19. 1-19-48 19 48 R. V. Beares  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-48 at 2a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 1-18-48 to 19

Immediate cause of death malformation of heart DURATION

Due to Pneumonia

Due to malformation of heart

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

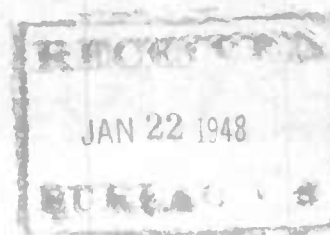
23. SIGNATURE R. V. Beares M. D. or other

Address Brunswick Date signed 1-19-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... St. Mary's  
 City or town..... Helen Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 weeks  
 Hospital, institution, or street address where death occurred:  
Helen Maryland  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... St. Mary's  
 City or town..... Praville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... R. F. D. # 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Thomas Slovin Harden  
 4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Dec 23 - 1947

8. AGE: Years..... Months..... Days..... 24 hrs..... min.....

9. Birthplace..... Lemartown St. Mary's Maryland  
(Town, county, and state)10. Usual occupation..... Expert

11. Industry or business.....

12. Name..... Joe S. Harden13. Birthplace..... St. Mary's Co14. Maiden name..... Mary Catherine Wether15. Birthplace..... St. Mary's Co16. Informant..... Joe S. HardenAddress..... Praville Maryland17. Burial..... Date thereof..... Jan 18, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... St. Joseph CemeteryLocation..... Maryland18. Funeral director..... W. C. MartinAddress..... Lemartown Md.19. 1/18..... 48..... Chambers  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 17..... 19..... 48 at..... 10:30 PM

21. CERTIFY that death occurred on the date above stated: that I attended deceased from.....

..... Jan 15..... 19..... 48 to..... Jan 17..... 19..... 48and that I last saw him/her alive on..... Jan 15..... 19..... 48

Immediate cause of death..... DURATION.....

Pneumonia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Paul D. Chambers..... M. D. or other.....Address..... Lemartown..... Date signed..... 1/18/48

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

YOUTH CENTER, N. Y.

RECEIVED  
JAN 20 1948  
ST. LOUIS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... St Marys  
 City or town... Clements Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... Life  
 Hospital, institution, or street address where death occurred:  
Clements Maryland  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... St Marys  
 City or town... Clements  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Edward B. Harrison

## 3. (b) Social Security Number

4. Sex... Male 5. Color or race... White 6.(a) Single, married, widowed, or divorced... married

6.(b) Name of husband or wife... Ella L. Harrison6.(c) If alive, give age... 58 years

7. Birth date of deceased (mo., day, yr.)... Aug. 7 - 1860

8. AGE: Years... 87 Months... 5 Days... 21 If less than one day... hrs. .... min.

9. Birthplace... Clements St Marys Md  
 (Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business...

12. Name... Thomas L. Harrison13. Birthplace... St Marys Co14. Maiden name... Elizabeth Bradshaw15. Birthplace... St Marys Co16. Informant... Mr Louis WelchAddress... 4900 Hamilton Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?)... Burial Date thereof... Jan 1948  
 (month) (day) (year)

Cemetery or crematory... St Joseph CemeteryLocation... Morgans Maryland18. Funeral director... W.C. Mattingly SonsAddress... Leonardtown Maryland19. 1/28 48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 27 19... 48 at... 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

...19... 30 to... Jan 27 19... 48and that I last saw h... alive on... Jan 24 19... 48

Immediate cause of death...

arteriosclerosis - coronaryDue to... Coronary

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... R.B. JohnsonAddress... MorgansM. D. ... Jan 27/48

Date signed...



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 256

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Princetown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County St. Mary's  
City or town Princetown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Henni Leminen Palmen

### 3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced married

8.(b) Name of husband or wife Rena Palmen

7. Birth date of deceased (mo., day, yr.) 8-31-1872 8.(c) If alive, give age 60 years

8. AGE: Years 70 Months 4 Days 5 If less than one day  
hrs. min.

9. Birthplace Princetown, md  
(Town, county, and state)

10. Usual occupation Principles Seafood Restaurant

### 11. Industry or business

12. Name John Palmen

13. Birthplace Dorchester Co. md

14. Maiden name Elizabeth Thomas in England

15. Birthplace Dorchester Co. md

16. Informant Robert V. Palmen

Address Princetown md

17. Burial Date thereof 1-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Princetown md

18. Funeral director W.E. Maltby Sons

Address Princetown md

19. 1-12-48 1948 R.V. Palmen  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8- 1948 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-3- 1947, to 1-8- 1948

and that I last saw him alive on 8-8- 1948

Immediate cause of death Gen. debility

inability to take

nutrition

Due to Cancer of

Esophagus & Throat

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmen M. D. or other

Address Princetown md Date signed 1-12-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Piney Point, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 6 mos.  
 Hospital, institution, or street address where death occurred:  
Dispensary, USNTR, Piney Pt. Md.  
 How long in hospital or institution? 8 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Marys  
 City or town Piney Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. U.S. Navy Torpedo Test Range.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Pruitt, Clarence "none"

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

Single

## 8.(b) Name of husband or wife

none

## 7. Birth date of

deceased (mo., day, yr.)

2-21-25

## 8. AGE:

Years

Months

Days

If less than one day

221010

hrs.

min.

## 9. Birthplace

West Virginia  
(Town, county, and state)

## 10. Usual occupation

Seaman U.S. Navy

## 11. Industry or business

U.S. Navy

## FATHER

## 12. Name

not known

## 13. Birthplace

## MOTHER

## 14. Maiden name

Fannie Pruitt

## 15. Birthplace

unknown

## 16. Informant

## Address

Personnel Office, US Navy  
USNTR, Piney Pt. Md.

## 17. Removal

(Burial, cremation, or removal. Which?)

## Date thereof

1/2/48  
(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

1/248Casualty

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

1-11948, at 2:15 P.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1, 1948, to January 1, 1948and that I last saw him alive on January 1, 1948

## Immediate cause of death

Intracranial Hemorrhage

## DURATION

8 hours

## Due to

## Due to

## Other conditions

(Include pregnancy within 9 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1-1-48Where did injury occur? Piney Point, St. Marys, Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public highwayMeans of injury auto accident Injured at work?

## 23. SIGNATURE

Robert L. Adair Lt. jg MC-USNR  
M. D. or otherAddress USNTR Piney Pt. Md. Date signed 1-2-48

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURYAL

PLACE OF REBURYAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURYAL

PLACE OF REBURYAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURYAL

PLACE OF REBURYAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

RECEIVED

JAN 3 1948

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
year of birth shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00843

HUN No. G 114 FEB 6- 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Marys  
City or town Holly wood md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Holly wood md  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
City or town Holly wood  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Inez Wise

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

8.(b) Name of husband or wife Vincent A. Wise

7. Birth date of deceased (mo., day, yr.) Dec 20 - 1887 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 62 Months \_\_\_\_\_ Days 30 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Holly wood St. Marys Md  
(Town, county, and state)

10. Usual occupation house wife

11. Industry or business same

12. Name Martin Gales

13. Birthplace St. Marys Co

14. Maiden name Jamie Bailey

15. Birthplace St. Marys Co

16. Informant Durant Wife

Address Holly wood Md

17. Burial Date thereof Jan 21 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Holly wood Maryland

19. Funeral director W.C. Mattingly Sons

Address Leonardtown Md

19. 1/20 19 48 Cavalier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 19 48 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to Jan 17 1948

and that I last saw him/her alive on Jan 18 1948

Immediate cause of death Pulmonary Hemorrhage

Due to Tuberculosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Francis F. Greenwell

Address Leonardtown Date signed 1-19-48

BY AUTHORITY OF THE STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
JAN 22 1948  
ST. ALBANS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Marys  
City or town Rural Ridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

James Walter Wood

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Calahia A. Wood

7. Birth date of deceased (mo., day, yr.)

April 30, 1871

5. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

76813

hrs.

min.

9. Birthplace

Wynne, Md  
(Town, county, and state)

10. Usual occupation

Veteran Sea-foal.

11. Industry or business

MOTHER FATHER

12. Name

James W. Wood

13. Birthplace

Maryland

14. Maiden name

Lucanna Haywood

15. Birthplace

Maryland

16. Informant

Jennison Wood

Address

St. Marys City, Md

17.

BurialDate thereof Jan 15/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Michaels Cemetery

Location

Ridge, Md

18. Funeral director

P. B. Robinson

Address

Leonardtown Md

19.

Jan 13/48  
(Date rec'd by registrar)P. B. Robinson  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

St. Marys

City or town

Rural Ridge  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Link Road  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 13, 1948, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August

1941

to

January 13, 1948

and that I last saw him alive on

Jan 11

1948

Immediate cause of death

Cerebral hemorrhage  
General arteriosclerosis

DURATION

1 hour.10 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. B. Robinson MD

M. D. or other

Address

Great Mills MdDate signed 1/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1948

BUREAU